Commonwealth of Massachusetts
Department of Public Health, Bureau of Health Professions Licensure
Drug Control Program
239 Causeway Street, Suite 500, Boston, MA 02114
Telephone 617-973-0949 Fax 617-753-8233

Amended Information Application for Massachusetts Controlled Substances Registration for Pharmacists

Please be sure to:

- Enter the name and MA Controlled Substance Registration (MCSR) number on current MCSR.
- No fee is charged when submitting a form to amend information.
- Enclose a copy of the DEA registration.
- Include a photocopy of your current Massachusetts Board of Registration Pharmacist license.
- Have form signed (not initialed) and dated. Mail to the address above.
- Send copies only of supporting documents. Do not send originals; they will not be returned

For further information, visit: http://www.mass.gov/dph/dcp.

This amended information is for: Registrant Name: _____MCSR No.:_____

Check the box to the left of the row(s) containing amended information. Please fill out the row(s) completely.

Amended	In the boxes below enter the requested information.
❑	1) Massachusetts Board of Registration License No. (New issue or changed):
❑	2) DEA Controlled Substance Registration No. (If possessed):
❑	3) Name: First: Middle: Last: Suffix: (e.g. Jr., Sr., II, III)
❑	4) Applicant Business Address: Applications with a P.O. Box number and no street address cannot be processed. Out-of-state addresses require a letter of explanation. Business/Facility Name (and Department if applicable):: Street: City: State: ZIP:
❑	5) Business Telephone No.: ( ) area code
❑	6) Social Security No.: (Required by M.G.L. c. 30A, s. 13A)
❑	7) Practice Setting: ❑ Hospital ❑ Long-term Care Facility ❑ Inpatient or Outpatient Hospice ❑ Ambulatory Care Clinic ❑ Community/Retail Pharmacy
❑	8) Drug Schedules requested: (Only Schedules that are checked can be authorized.) Select all that apply: ❑ II ❑ III ❑ IV ❑ V ❑ VI A pharmacists practicing in Community/Retail pharmacy may only select Schedule VI.
❑	9) E-mail Address: (Optional)
❑	10) Have you ever been convicted of any violation of State or Federal law relating to the manufacture, possession, distribution or dispensing of controlled substances? ❑ Yes * ❑ No
❑	11) Has any previous professional license or registration held by you under any name or corporate name or legal entity been surrendered, revoked, suspended or denied or is such action pending? ❑ Yes * ❑ No

* If you answered "Yes" to Question No. 10) or No. 11), a letter must be attached setting forth circumstances of such action(s).

Applicant name: _____

- ❑ Check here if adding a new supervising physician.
- ❑ Check here if amending any of the current supervising physician's information.

If **not** adding or amending Supervising Physician's Information, **do not** enter information in question 12)

Do not forget to sign and date the application at the bottom of this page.

Supervising Physician's Information	
12) The following Supervising Physician's information must be completed for each physician supervising your practice. The supervising physician is the individual with whom you, the applicant, have developed and signed a collaborative practice agreement. If you practice in more than one medical specialty or in more than one setting (e.g., more than one employer), you must complete this section for each supervising physician for each medical specialty and/or setting. You may make photocopies of this page as necessary.	
Name of Supervising Physician:	Telephone No. ( ) area code
Business Address:	
Board of Medicine License No.:	Massachusetts Controlled Substances Registration No.:
DEA Controlled Substance Registration No.:	Medical Specialty:
13) Is there a developed written and signed collaborative practice agreement in place? ❑ Yes ❑ No A written collaborative practice agreement is required for Pharmacist CDTM. Applications not checked Yes will be returned.	
14) Please indicate in which setting the collaborative practice agreement applies: ❑ Hospital ❑ Long-term Care Facility ❑ Inpatient or Outpatient Hospice ❑ Ambulatory Care Clinic ❑ Community/Retail Pharmacy	
Signature of Supervising Physician (no initials): _____ Date _____	

- ❑ Check here if deleting a supervising physician by whom you are no longer supervised.

Deleted Supervising Physician
15) Name of supervising physician to delete:

I hereby certify that (1) the information on this application is true to the best of my knowledge; (2) I possess a written collaborative practice agreement that was mutually developed, agreed upon, and signed by my supervising physician and me; (3) I will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations of the Department of Public Health and the Board of Registration in Pharmacy (247 CMR), whichever is applicable; and (4) I will complete, in each year of the term of the agreement, at least 5 additional contact hours or 0.5 continuing education units of Board of Registration in Pharmacy approved continuing education that address areas of practice generally related to the particular collaborative practice agreement. I also certify, in accordance with M.G.L. c. 62C, section 49A, that I have to the best of my knowledge and belief complied with all laws of the commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support.

Signed under the pains and penalties of perjury.

Signature of applicant (no initials) _____ Date _____

If you have questions, you may call the Drug Control Program at 617-973-0949.